

Please complete this form with the exposed health care worker.

Massachusetts Department of Public Health Bloodborne Pathogen Exposure Incident Recording Form

EMPLOYER:*						UNIQUE EXPOSURE INCIDENT NUMBER:*					
EXPOSED WORKER'S NAME: (or unique ID number)						OSHA RECORDABLE: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN					
STATUS of EXPOSED WORKER:						TIME WORK SHIFT BEGAN:* : am pm					
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER <input type="checkbox"/> NON EMPLOYEE PRACTITIONER <input type="checkbox"/> TEMP / CONTRACT <input type="checkbox"/> STUDENT _____											
DATE OF INCIDENT:*/ /			TIME of INCIDENT:*/ : am pm			DATE REPORTED:*/ /			TIME REPORTED: : am pm		
TYPE OF EXPOSURE:*			TYPE OF FLUID:			FOR PERCUTANEOUS INJURIES: DEPTH OF INJURY:			BLOOD VISIBLE ON DEVICE BEFORE EXPOSURE?		
<input type="checkbox"/> Percutaneous <input type="checkbox"/> Mucous membrane <input type="checkbox"/> Skin Was skin intact?: YES NO UNKNOWN <input type="checkbox"/> Bite			<input type="checkbox"/> Blood / blood products <input type="checkbox"/> Visibly bloody body fluid <input type="checkbox"/> Non-visibly bloody body fluid <input type="checkbox"/> Visibly bloody solution (iv fluid, etc.) <input type="checkbox"/> Non-visibly bloody solution <input type="checkbox"/> Other _____ (specify) <input type="checkbox"/> Unknown			<input type="checkbox"/> Superficial <input type="checkbox"/> Moderate <input type="checkbox"/> Deep <input type="checkbox"/> Unknown			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
BODY PART INJURED:						PERSONAL PROTECTIVE EQUIPMENT WORN BY WORKER AT TIME OF EXPOSURE:					
<input type="checkbox"/> Arm <input type="checkbox"/> Mouth / nose <input type="checkbox"/> Hand <input type="checkbox"/> Leg <input type="checkbox"/> Finger <input type="checkbox"/> Other _____ (specify)						<input type="checkbox"/> Gloves (single pair) <input type="checkbox"/> Eye protection <input type="checkbox"/> Other _____ (specify) <input type="checkbox"/> Gloves (double pair) <input type="checkbox"/> Face shield <input type="checkbox"/> Gloves (triple pair) <input type="checkbox"/> Gown/Garment <input type="checkbox"/> None of the above <input type="checkbox"/> Mask					
OCCUPATION:*											
<input type="checkbox"/> Attendant / orderly <input type="checkbox"/> Fellow <input type="checkbox"/> Medical student <input type="checkbox"/> Physical therapist <input type="checkbox"/> Attending physician <input type="checkbox"/> Fireperson / First responder <input type="checkbox"/> Nurse Anesthetist <input type="checkbox"/> Public health worker <input type="checkbox"/> Central supply <input type="checkbox"/> Food service <input type="checkbox"/> Nursing Assistant <input type="checkbox"/> Psychiatric technician <input type="checkbox"/> Clerical / administrative <input type="checkbox"/> Hemodialysis technician <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Radiologic technician <input type="checkbox"/> Clinical lab technician <input type="checkbox"/> Housekeeper <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Counselor / social worker <input type="checkbox"/> Intern / resident <input type="checkbox"/> Nursing student <input type="checkbox"/> Researcher <input type="checkbox"/> Dentist <input type="checkbox"/> Laundry staff <input type="checkbox"/> OR / surgical technician <input type="checkbox"/> Respiratory Therapist / tech <input type="checkbox"/> Dental assistant / tech <input type="checkbox"/> Law enforcement officer <input type="checkbox"/> Patient care technician <input type="checkbox"/> Safety / security <input type="checkbox"/> Dental hygienist <input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Pharmacist <input type="checkbox"/> Transport / messenger <input type="checkbox"/> Dental student <input type="checkbox"/> Maintenance <input type="checkbox"/> Phlebotomist <input type="checkbox"/> Volunteer <input type="checkbox"/> Dietician <input type="checkbox"/> Morgue technician <input type="checkbox"/> Physician assistant <input type="checkbox"/> Other _____ (specify) <input type="checkbox"/> EMT / paramedic											
DEPARTMENT OR WORK AREA WHERE EXPOSURE INCIDENT OCCURRED:*											
Identify specific location (room number, floor etc): _____ Select all that apply											
<input type="checkbox"/> Ambulance <input type="checkbox"/> Endoscopy / bronchoscopy <input type="checkbox"/> Intensive care unit <input type="checkbox"/> Obstetrics / gynecology ward <input type="checkbox"/> Blood bank <input type="checkbox"/> /cytoscropy <input type="checkbox"/> Jail unit <input type="checkbox"/> Operating room <input type="checkbox"/> Central sterile supply <input type="checkbox"/> Exam room <input type="checkbox"/> Labor and delivery <input type="checkbox"/> Pediatrics <input type="checkbox"/> Central trash area <input type="checkbox"/> Hematology <input type="checkbox"/> Laundry room <input type="checkbox"/> Procedure room <input type="checkbox"/> Clinical chemistry <input type="checkbox"/> Histology / pathology <input type="checkbox"/> Medical / surgical ward <input type="checkbox"/> Psychiatry ward <input type="checkbox"/> Dialysis <input type="checkbox"/> Home health visit (home) <input type="checkbox"/> Microbiology <input type="checkbox"/> Radiology department room <input type="checkbox"/> Dental Clinic <input type="checkbox"/> Hospital grounds <input type="checkbox"/> Morgue / autopsy room <input type="checkbox"/> Other location_____ <input type="checkbox"/> Emergency Department <input type="checkbox"/> Nursery (specify)											
IS THIS THE DEPARTMENT TO WHICH THE WORKER IS REGULARLY ASSIGNED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A											
IF NO, TO WHICH DEPARTMENT IS THE WORKER REGULARLY ASSIGNED?											

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REQUIRED DATA ELEMENTS FOR RECORDING*WHAT DEVICE OR ITEM WAS INVOLVED IN THE INJURY?*****Hollow bore needle**

- ☐ Biopsy needle
☐ IV stylet
☐ Hollow-bore needle, type unknown
☐ Huber needle
☐ Hypodermic needle attached to a disposable syringe
☐ Hypodermic needle attached to IV tubing
☐ Prefilled cartridge syringe
☐ Spinal or epidural needle
☐ Unattached hypodermic needle
☐ Winged steel needle
☐ Winged steel needle attached to a vacuum tube collection holder
☐ Winged steel needle attached to IV tubing
☐ Vacuum tube collection holder / needle
☐ Other type of hollow bore needle

 (specify)

Other sharp object

- ☐ Bone chip / chipped tooth
☐ Bone cutter
☐ Bovie electrocautery device
☐ Bur
☐ Explorer
☐ Histology cutting blade
☐ Lancet
☐ Laser
☐ Pin
☐ Razor
☐ Retractor
☐ Scaler / curette
☐ Scalpel blade
☐ Scissors
☐ Sharp object, type unknown
☐ Tenaculum
☐ Trocar
☐ Wire
☐ Other type of sharp object _____
 (specify)

Suture needle

- ☐ Curved suture needle
☐ Straight suture needle

Glass

- ☐ Capillary tube
☐ Medication ampule / vial / IV bottle
☐ Pipette
☐ Slide
☐ Specimen / test / vacuum tube
☐ Other glass item _____
 (specify)

Additional dental / surgical devices

- ☐ Hypodermic needle attached to non-disposable syringe
☐ Elevator
☐ Extraction forceps
☐ Root canal file
☐ Rod (orthopaedic)
☐ Other device or item _____
 (specify)

BRAND / MODEL OF DEVICE:***WAS IT A SAFETY DEVICE?** ☐ Yes ☐ No ☐ Unknown**IF YES, WHEN DID THE INJURY OCCUR?**

- ☐ Before activation of safety feature
☐ During activation of safety feature
☐ Safety feature improperly activated
☐ Safety feature failed; after activation
☐ Safety feature not activated
☐ Passive safety feature, activation not required
☐ Other _____
 (specify)

IF YES, WAS THE WORKER TRAINED IN THE PROPER USE OF THIS SAFETY DEVICE?

- ☐ Yes
☐ No

Describe training:

PURPOSE OR PROCEDURE FOR WHICH SHARP WAS USED OR INTENDED:***Line procedures:**

- ☐ To insert a peripheral IV line or set up a heparin lock
☐ To insert a central IV line
☐ To insert an arterial line
☐ To connect IV line (intermittent IV / piggy back / IV infusion / other IV line connection)
☐ To flush heparin / saline
☐ Other injection into IV injection site or IV port
 _____ (specify)
☐ Other line procedure _____
 (specify)

Blood procedures:

- ☐ Percutaneous venous puncture (e.g. phlebotomy)
☐ Percutaneous arterial puncture
☐ Central or peripheral IV line or port
☐ Arterial line
☐ Dialysis / AV fistula site
☐ Umbilical vessel
☐ Fingerstick / heel stick
☐ Other blood sampling _____
 (specify)

Other procedures:

- ☐ Cutting (e.g. surgery / autopsy)
☐ During disposal
☐ Epidural / spinal anesthesia
☐ Intramuscular (IM) injection
☐ Subcutaneous / intradermal injection / skin test placement
☐ Suturing
☐ Transferring blood / body fluid to another container
☐ To obtain a body fluid or tissue sample (CFS / amniotic / biopsy)
☐ To obtain laboratory specimens
☐ Other procedure (not a line procedure or blood sampling procedure)

 (specify)
☐ Unknown

Dental procedure:

- ☐ During disposal
☐ Hygiene (prophy, root plane, curettage)
☐ **Oral surgery**
☐ Simple Extraction
☐ Surgical Extraction
☐ Fracture Reduction
☐ Other _____
 (specify)
☐ Unknown
☐ Orthodontic procedure
☐ Periodontal surgery
☐ Restorative (amalgam, composite, crown)
☐ Root canal
☐ Other _____
 (specify)
☐ Unknown

Where did the injury occur?

- ☐ Inside the patient's mouth
☐ Outside the patient's mouth
☐ Unknown

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***REQUIRED DATA ELEMENTS FOR RECORDING**

HOW DID THE INJURY OCCUR?*

Choose up to two

☐ Before use of the item

During use of the item

☐ Collided with co-worker or other person

☐ Collided with sharp

☐ Incising

☐ Manipulating suture needle in holder

☐ Palpating / Exploring

☐ Passing or receiving equipment

☐ Passing or transferring equipment

☐ Patient moved and jarred device

☐ Sharp object dropped

☐ Suturing

☐ Tying sutures

☐ While inserting needle in line

☐ While inserting needle in patient

☐ While manipulating needle in line

☐ While manipulating needle in patient

☐ While withdrawing needle from line

☐ While withdrawing needle from patient

☐ Other _____
(specify)

☐ Unknown

After use, before disposal

☐ Activating safety device

☐ Cap fell off after recapping

☐ Collided with co-worker or other person

☐ Collided with sharp after procedure

☐ Disassembling device or equipment

☐ Decontamination / processing of used equipment

☐ During clean-up

☐ Handling equipment on a tray or stand

☐ In transit to disposal

☐ Opening / breaking glass containers

☐ Processing specimens

☐ Passing or transferring equipment

☐ Recapping (missed or pierced cap)

☐ Sharp object dropped after procedure

☐ Struck by detached I.V. line needle

☐ Transferring blood / bodily fluids into specimen container

☐ Other _____
(specify)

☐ Unknown

During or after disposal of item

☐ Collided with co-worker or other person

☐ Collided with sharp during / after disposal

☐ In trash

☐ In linen / laundry

☐ In pocket / clothing

☐ Left on table / tray

☐ Left in bed / mattress

☐ On floor

☐ Over-filled sharps container

☐ Punctured sharps container

☐ Protruding from opened container

☐ Sharp object dropped during / after disposal

☐ Struck by detached I.V. line needle during / after disposal

☐ While manipulating container

☐ While placing sharp in container, injured by sharp being disposed

☐ While placing sharp in container, injured by sharp already in container

☐ Other _____
(specify)

☐ Unknown

NARRATIVE DESCRIPTION OF THE INCIDENT:

WHAT SUGGESTIONS DOES THE WORKER HAVE FOR PREVENTING SIMILAR INJURIES IN THE FUTURE?

Prepared by:

Date:

Title:

